The Children and Family Eye Doctors, a division of Proliance Surgeons
17130 Avondale Way Ste 111
Redmond, WA 98052
425-885-6600
Fax: 425-885-6580

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name _____ Date of Birth _____

Previous Name _____ SSN _____

I give permission for the following organization to release patient information as stated below.

Information to be released from:	Information to be released to:
Organization/Persons Name	Organization/Persons Name
Address	Address
Fax	Fax
Phone	Phone

Describe the type of health information that may be disclosed, i.e. patient records, tests:

Describe the purpose for which the information will be used or disclosed, i.e. continuing care, copies for own use:

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/ or alcohol use, you are specifically authorized to release all health care information related to such diagnosis, testing and treating.

I have the right to revoke the authorization at any point before it is processed. I understand that the information can be redisclosed by the recipient and will not longer be protected.

_____

Signature of patient or patient's authorized representative Date signed

_____

Relationship or status, if signed by anyone other than patient (parent, legal guardian, personal rep, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED

A copy of this signed authorization must be given to the patient or the patients representative. 03/03, revised 04/04, 04/05